Amendment to Plan of Benefits

For Employees of: The Department of Defense Nonappropriated Fund Health Benefits Program
Administrative Services Agreement No.: 721027
Contract Number: NAFBA 1-99-C-0012

Effective January 1, 2005, the following changes have been made to your 2003 Summary Plan Description (SPD). Your 2003 SPD has been amended twice since it was published. Please consult the amendment issued in 2004 (Amend: 3) as well as this amendment issued in 2005 (Amend: 4) for details on the NAF HBP.

A. Prescription drug copayments have changed. The following chart entitled, "**Prescription Drug Coverage**" replaces the one currently appearing in your Summary Plan Description on page 9.

Prescription Drug Coverage

When the prescription is purchased through:	**And the prescription is for a "generic" drug, the expense is covered at:**	**And the prescription is for a "brand-name" drug listed on the Aetna's current formulary, the expense is covered at:**	**And the prescription is for a "brand-name" drug <u>not</u> listed on the Aetna's current formulary, the expense is covered at:**
Mail Order Pharmacy - Aetna Rx Home Delivery*	100% after a $20 copay per prescription or refill for up to a 90-day supply	100% after a $40 copay per prescription or refill for up to a 90-day supply	100% after a $60 copay per prescription or refill for up to a 90-day supply
A Participating Pharmacy	100% after a $10 copay per prescription or refill up to a 30-day supply	100% after a $25 copay per prescription or refill up to a 30-day supply	100% after a $35 copay per prescription or refill up to a 30-day supply
A Non-Participating Pharmacy in the US	No Coverage	No Coverage	No Coverage
Overseas Pharmacies	100% after deductible	80% after deductible	80% after deductible

* The Mail Order Pharmacy feature of the Prescription Drug Benefit is designed to be used by individuals using maintenance type medication for the treatment of chronic or long-term conditions such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure, for periods of 30 days or longer. This program covers any prescription drug covered by the Plan.

Copayments as listed above are to be paid at the Participating Pharmacy at the time of purchase. No other prescription drug benefits are payable. Do not submit prescription drug claims for prescription drugs obtained in the U.S.

Refills for prescription drugs will be filled in accordance with the terms of the Plan, provided that:

- *for a 10 to 30 day supply at least 50% of the prior prescription or refill has been used; or*
- *for a supply greater than 30 days at least 75% of the prior prescription or refill has been used; or*
- *for a supply furnished by a **mail order pharmacy** at least 60% of the prior prescription or refill has been used.*

The date of the most recent prescription or refill will be used to determine the percentage used.

B. If you are enrolled in the Open Choice PPO Plan, the copay amount has changed for services received in an emergency room. The "Non-Preferred Emergency Room Deductible or Preferred Emergency Room Copay" has been changed from $100 to $150. Please note this change in your Summary of Coverage under "Deductible Amounts" on page 11. Additionally, the rows entitled "Emergency Room Treatment " and "Non-Emergency use of the Emergency Room" currently appearing in the chart entitled, "Payment Percentage" on page 11 of your SPD are replaced with the following rows.

Payment Percentage

Hospital Expenses	**Preferred Care Benefits**	**Non-Preferred Care Benefits**
Emergency Room Treatment	100% after $150 hospital emergency room copay*	100% after deductible and $150 hospital emergency room deductible*
Non-emergency use of the Emergency Room	50% after $150 hospital emergency room copay	50% after deductible

***** The emergency room deductible and copay will be waived if a person is admitted to the hospital as an inpatient immediately following a visit to a hospital emergency room.

C. The Healthy Outlook Disease Management Program has been added to your "**Comprehensive Medical Expense Coverage**" section of your SPD which starts on page 18 of your Open Choice (PPO) SPD or page 16 of your Traditional Choice SPD, whichever SPD is applicable. The Healthy Outlook Disease Management Program involves the identification of employees who have, or may be at risk for certain chronic diseases. Participation in the program is voluntary. The program is aimed at focusing appropriate treatment for employees who have been identified as having diabetes or chronic heart failure.

The Healthy Outlook Disease Management Program utilizes:

- Prevention
- Early detection
- Targeted activity
- Member education

- Physician interaction; and
- Participation by the employee in self-care.

A “participant” in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by:

  his or her attending physician or other health care provider; or

  Aetna; and

- who is approved by Aetna as a participant.

The educational materials and the management of the chronic condition are provided at no additional cost to you; the Covered Medical Expenses provided by physicians, hospitals or other providers are paid at the payment percentage as shown under the applicable category in the Payment Percentage chart found in your Summary Plan Description.

D. The following bullet is added to the "**General Exclusions Applicable to Health Expense Coverage**" section of your SPD on page 46 of your Open Choice (PPO) SPD or on page 40 of your Traditional Choice SPD, whichever SPD is applicable.

- Those for charges for failure to keep an appointment.

E. The following paragraph is added as the last paragraph in the "Other Plan" subsection found in the "**Coordination of Benefits**" section of your Summary Plan Description. The purpose is for clarification of page 51 of your Open Choice (PPO) SPD or on page 45 of your Traditional Choice SPD, whichever SPD is applicable:

Medical coverage under this Plan will be coordinated with other Medical plans. Pharmacy coverage under the Prescription Drug Expense Coverage section of this SPD will not be coordinated with other Pharmacy plans.

F. The last three paragraphs found under the section, "**Continuation of Coverage For Surviving Dependents**" on page 57 of your Open Choice (PPO) SPD or on page 51 of your Traditional Choice SPD, whichever SPD is applicable, are replaced by the following four paragraphs.

Under the above sections, any dependents’ coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.

If Health Expense Coverage is being continued for your dependents, the following dependents may also be covered:

- Your child conceived prior to your death; or
- An adopted child, whose legal process for adoption was initiated by you or your spouse prior to your death.

The completed enrollment form must be returned to your Human Resources Manager within 31 days of the date the child is born, adopted or "placed for adoption" (this means the assumption

and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child).

Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

G. The following section entitled, "Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law" is added to the **"Temporary Continuation of Coverage Program"** section of your SPD which starts on page 73 of your Open Choice (PPO) SPD or on page 66 of your Traditional Choice SPD, whichever is applicable. This section is also added prior to page 27 of your Dental Summary Plan Description.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). You are eligible for FMLA if you have at least 12 months of service for your Employer. An eligible employee is entitled to 12 administrative workweeks of unpaid leave during any 12 month period for specified family and medical needs.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses will be available to you under the Temporary Continuation of Coverage Program.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for coverage under the Temporary Continuation of Coverage Program on the same terms as though your employment terminated, other than for termination of cause , on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within

31 days, and still want coverage, you will need to enroll in the Plan during the next open enrollment period.

If any coverage under the Temporary Continuation of Coverage Program terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

H. If you are enrolled in the Dental Plan, the following bullet has been added for clarification purposes to the "**Exclusions**" section of your Dental Summary Plan Description which can be found on page 13.

- Analgesia, Anxiolysis, Inhalation of Nitrous Oxide and Local Anesthesia, except when billed as part of a covered procedure.

I. The following bullet is added to the "**General Exclusions Applicable to Dental Expense Coverage**" section on page 14 of your Dental Summary Plan Description.

- Those for charges for failure to keep an appointment.